GUEST EDITORIAL: PHYSICIAN REIMBURSEMENT FOR CARE OF THE ELDERLY: CONCERNS OF A PRACTICING GERIATRICIAN*

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THE past decade of growth in geriatric medicine has focused on academic medical centers attempting to develop educational, clinical, and research programs involving multiple institutional settings. Little attention has been paid to noninstitutionally based practitioners of geriatric medicine. Although more than 50% of geriatric fellows-in-training are interested in delivering primary care after graduation,[1] the need for community-based practitioners in geriatric medicine is debated amongst academicians, health care planners, legislators and primary care providers. The present and future role of community based geriatricians remains unclear, undocumented, speculative, and, in these changing times of decreasing Medicare dollars, risky business.

PROBLEMS WITH EXISTING PROPOSALS

All of the proposals offered to revamp the payment of physicians for care of the elderly (e.g., relative value scales, mandatory assignment of inpatient fees, physician diagnostic related groupings, or Medicare capitation) have two basic shortcomings.[2,3]

First, none of the options involve any type of quality assurance to monitor the effect of possible reduced amounts of physician intervention on patient outcome. Cost-driven public policy has made quality of care for the elderly a low priority. For example, if all older patients are cared for in the hospital by physicians who must accept mandatory assignment, what will be the effect upon the care of older patients of decreased physician reimbursement? Will older patients who truly need hospitalization be diverted to offices where nonassigned dollars can be garnered, and, if so, at what

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health expense? If the government requires physicians to accept assignment in the office on all Medicare patients, how much less time will be spent with them and at what health cost? Paradoxically, primary care physicians are reported to spend 7% less time with their older patients during office visits and 18% less time during hospital visits than with middle aged adults.[4]

The second shortcoming of current proposals is that none suggest using the expertise of geriatricians, physicians specially trained in the care of the elderly and who, therefore, are likely to improve the care of older patients regardless of the financial mechanism for reimbursement.

Furthermore, the assumption that a significant amount of total personal health care expenditures will be saved by decreasing physician's fees is questionable. For every 10% reduction in money spent for physician services, dollars spent for national personal health care expenditures are reduced by only 2%.[5] This negligible change occurs because only one out of five personal health care dollars in the United States goes to private medical practitioners. Physician services account for 15% of all federal dollars spent on personal health care. A 10% reduction in fees paid by the federal government to physicians would result in a mere 1.5% decrease in federally paid dollars for personal health care under Medicare, Medicaid, and all other federally financed programs.[6]

The effect of the geriatrician upon the disabilities of frail older adults has to be differentiated from any geriatric gatekeeper function. Geriatric gatekeeping, whereby a primary care physician approves all care provided to his elderly patient,[7] is a complex undocumented art. It may be associated with substantial risks, such as not admitting a sick older adult to the hospital, not having a consultant evaluate a patient, or prematurely discharging such a patient, all to save health care dollars. Certainly few data support the scientific and clinical skills necessary for geriatric gatekeeping in the primary care setting. While health maintenance organizations decrease hospitalization rates by as much as 40% in middle aged and younger populations when compared with fee-for-service physicians,[8] similar forms of gatekeeping with the elderly who make up only 2.5% of HMOI, enrollees have not been systematically evaluated with regard to quality assurance and cost savings.[9]

Equitable Reimbursement for Geriatric Care: Relative Value Scales

Geriatricians stand to benefit if a new fee system is developed using a relative value scale that rewards "thinking" (nonprocedural) time and "tech-

nology'' (procedural) time more equitably. Specifically, implementation of a physician fee schedule, such as that based on a reimbursement methodology utilized in the Hsiao-Stason study at the Harvard School of Public Health, would equalize the discrepancy between cognitive and technological interventions.[10] The initial study assigned relative values to 25 surgical procedures and to two office visits. These fees were based on resource costs, which include money spent in training, overhead, time to perform the procedure, and complexity of the procedure. The Commission concluded that, relative to office visits, traditional reimbursement levels overvalued most surgical procedures. Subsequently, under this new system, reimbursement for office visits and other primary care services was increased from 12 to 83%.

Geriatricians stand to benefit if relative value scales are modified to pay higher rates for particular services to frail populations of older adults. Increased time is often necessary for history taking, physical, neurological and psychiatric examinations and discussions with the patient, multiple family members, and other health care professionals. The complexity of the patient's diseases, disabilities, and drug regimens, and the need for case management of rehabilitation, home health care, and social work services for selected elderly patients add to the time and skills required. Physicians who give primary or consultative care to the frail elderly should benefit from a larger payment for services in office, hospital, patient's home and nursing home—perhaps promoting physician visits to the latter two settings.

Relative value scales should be altered for the patient's age and disability to encourage care of complex, time-consuming elderly patients. Payment to general internists or geriatricians who care for these frail elderly would be adjusted upward for increased disability, deteriorated activities of daily living status, or, much less likely, chronological age. Geriatric evaluations, including assessment of mental and physical function, rehabilitation potential, activities of daily living status, and coordination of overall care, are skills that warrant higher relative values. Such a scale would discourage primary care physicians from abandoning their most complicated, time-consuming elderly patients or from building practices of healthy, older adults who are much less time consuming (i.e., ''patient skimming'').

This concept recognizes the wide range of health and function among the elderly, and reimburses accordingly. None of the proposed reimbursement approaches speaks to the variability of disease or function in the frail elderly or to the effect that multiple diseases have on the extent or length of subsequent disability. How to reimburse physicians properly for these confounding

variables remains to be seen. A relative value scale, plus a variable increment, is a logical approach.

Disincentives to Geriatric Practice: A Caution to Colleagues

There are major disincentives for geriatric fellows to pursue careers as practicing geriatricians in selected community settings. Once a physician announces his expertise in geriatrics to both the lay and medical community, a number of things happen. The geriatrician becomes defined mainly as a doctor for frail older people, not for the young-old, the healthy old, nor middle aged adults interested in health promotion and disease prevention. Currently, the typical adult patient may feel that a geriatrician has little to offer with regard to disease prevention and health promotion in late life beyond what their current primary care giver delivers. The community's perception of the geriatrician leads to referrals of the frailest elderly who have the highest death rate, are most likely to enter nursing homes, or to be moved from relative to relative. These referral patterns result in a high loss of patients from the practice.

Another disincentive is that the geriatrician's total income is based upon services delivered to older adults, all of whom are Medicare recipients. The geriatrician is most vulnerable to any financial restrictions that Medicare places on physicians, hospitals, nursing homes, and home care services. These real and potential constraints require a diversification of income sources. All physician charges under Medicare were frozen in 1984, and Medicare reimbursement to patients was further reduced by 1% in 1986 under the Gramm-Rudman-Hollings Deficit Reduction Act. The Consolidated Omnibus Budget Reconciliation Act requires mandatory acceptance of assignment for office laboratory testing, including venipuncture. In 1987 the Maximum Allowable Actual Charge has resulted in only a 1% increase, in many cases, for fees charged to patients after the three-year freeze. Since almost all patients who visit geriatricians are Medicare recipients, a two-tier fee system—one for Medicare patients and one for non-Medicare patients—thereby offsetting the decrease in income, is not possible. Given the existing "cap" on fees and the prospect of decreasing income and rising operating costs, there is little impetus to accept Medicare assignment. Accepting assignment will serve only to increase patient load, since many older adults would prefer to see a geriatric specialist for a minimal fee (their yearly deductible plus 20% copayment), and to lessen the time spent per pa-

tient. Quality is sure to fall. In a sense, not accepting assignment or limiting the number of assigned patients to a minority acts as a gatekeeper.

CONCLUSION

Colleagues must be cautioned about a community practice catering mainly to the elderly. Federal and subsequent private insurance cost cutting will affect the quality of care that can be delivered. It is unlikely that sound geriatric care can be incorporated into an economic system committed to decreasing expenditures for the health care of the most vulnerable component of our adult population—the frail elderly. It is ironic that the developing field of geriatrics may be stifled because multiple financial constraints lower physician reimbursement. It is hard to believe that the sons and daughters who bring their elderly parents to a geriatrician's office are aware that an uncontrolled reimbursement experiment has been undertaken by the federal government that could be detrimental to their mother's or father's health.

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